

NY STATE CLIENT SEMI-ANNUAL REPORT

Marking Instructions: Please type or use blue or black ink pen.
 Completely fill in one circle.
 Print legible numbers and block letters, no script.

COMPLETE ALL SECTIONS
 before submitting or form will be returned.

Reporting Information

Year: 2012

Fill in circle if amendment ☒

Report Period: ☐ January/June ☒ July/December

Type of Lobbying: ☐ Nonprocurement ☐ Procurement ☐ Both

Client Filing Fee Check Number:

FOR OFFICE USE ONLY

RECEIVED JAN 18 2013

Client Information

Name: Medical Society of the State of New York

Permanent Business Address: 99 Washington Avenue, Suite 408

City: Albany

State: NY

ZIP code: 12210

Business Phone: (518) 465-8085

Fax Number: (518) 465-8085

Third Party Beneficiary (see instructions):

Lobbyist(s) Information & Compensation (Current Period Only)

Any individual or organization that has lobbied on behalf of the client must be reported below, regardless of whether the threshold was exceeded by that individual or organization.

A Type of Lobbyist: ☐ Retained ☐ Employed ☐ Designated

Level of Gov't: ☐ State Lobbying ☐ Local Lobbying ☐ Both

Name:

Phone Number:

Address:

City:

State:

ZIP code:

Compensation for current period: \$.00

B Type of Lobbyist: ☐ Retained ☐ Employed ☐ Designated

Level of Gov't: ☐ State Lobbying ☐ Local Lobbying ☐ Both

Name:

Phone Number:

Address:

City:

State:

ZIP code:

Compensation for current period: \$.00

C Type of Lobbyist: ☐ Retained ☐ Employed ☐ Designated

Level of Gov't: ☐ State Lobbying ☐ Local Lobbying ☐ Both

Name:

Phone Number:

Address:

City:

State:

ZIP code:

Compensation for current period: \$.00

☐ Continued on attached pages

D TOTAL COMPENSATION of ALL lobbyists for current period.....(A+B+C+addendum sheets): \$.00

Other Expenses (Current Semi-Annual Period Only)

A Report in the aggregate all expenses less than or equal to \$75:	\$.00
B Report in the aggregate all expenses for salaries of non-lobbying employees:	\$.00
C Itemize each expense exceeding \$75:		
PAID TO:	DATE: / /	<input type="radio"/> Ad <input type="radio"/> Social Event
PURPOSE:	AMOUNT: \$.00	<input type="radio"/> *Addendum attached
<input type="radio"/> PROCUREMENT <input type="radio"/> NONPROCUREMENT		
PAID TO:	DATE: / /	<input type="radio"/> Ad <input type="radio"/> Social Event
PURPOSE:	AMOUNT: \$.00	<input type="radio"/> *Addendum attached
<input type="radio"/> PROCUREMENT <input type="radio"/> NONPROCUREMENT		
<input type="radio"/> Continued on attached pages		
* If any expense listed above exceeds \$75 for an individual, you must attach the addendum page listing the expense, dollar amount attributable to the individual and the name, title and employer of the individual.		
D Total expenses for current period: \$.00 (if applicable, include all expenses from attached pages in total)		

Source of Funding Disclosure

Instructions: In the event only one person or entity is listed as the Single Source for a Contribution(s), use Section A. In the event multiple persons or entities have been aggregated as a Single Source for a Contribution(s), use Section B.

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received. If more than five Contributions from the Single Source have been received, use section V(C) of the Addendum for the additional Contributions.

Contribution(s) from Single Source #1

Single Source Entity's Name: Pfizer, Inc.

RECEIVED JAN 16 2013

or
Single Source Person's Last Name:

First Name:

Address: 235 East 42nd Street

City: New York

State: NY

ZIP code: 10017-5755

Phone: (901) 215-1111

Date Contribution Received: 07 / 17 / 2012

Amount of Contribution: \$ 1700 .00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐**Contribution(s) Single Source #2**

Single Source Entity's Name: AstraZenica Pharmaceuticals LP

or
Single Source Person's Last Name:

First Name:

Address: 1800 Concord Pike, PO Box 15437

City: Wilmington

State: DE

ZIP code: 19850

Phone: (302) 886-3000

Date Contribution Received: 12 / 5 / 2012

Amount of Contribution: \$ 850 .00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐Check here if there are Contribution(s) from Single Source(s) other than those listed above. Use Section V(A) of the Addendum to list all such Contributions: ☒

Designated Addendum sheet for section V(A)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

Source of Funding Disclosure

A Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

Contributions from Single Source #3

Single Source Entity's Name: Physicians' Reciprocal Insurers

or

Single Source Person's Last Name:

First Name:

Address: 1800 Northern Blvd, PO Box 9007

State: NY

ZIP code: 11576

City: Roslyn

Phone: (516) 365-6690

Date Contribution Received: 11 / 29 / 2012

Amount of Contribution: \$22537 .00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions:

**Contributions from Single Source # 4**

Single Source Entity's Name: Medical Liability Mutual Insurance Company

or

Single Source Person's Last Name:

First Name:

Address: 2 Park Avenue, Suite 5000

State: NY

ZIP code: 10016

City: New York

Phone: (212) 576-9800

Date Contribution Received: 07 / 02 / 2012

Amount of Contribution: \$ 42500 .00

Date Contribution Received: 10 / 05 / 2012

Amount of Contribution: \$ 42500 .00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions:

**Contributions from Single Source # _____**

Single Source Entity's Name:

or

Single Source Person's Last Name:

First Name:

Address:

State:

ZIP code:

City:

Phone:

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Date Contribution Received: / /

Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions:



Source of Funding Disclosure

B Single Source information for a Contribution(s) from multiple, Related, or Affiliated Entities.

Contributions from Single Source #1

Related or Affiliated Entity or Person: John Mather Memorial Hospital at St. Charles

Entity's or Person's Full Name:

Entity's or Person's Address: 75 N Country Rd, Port Jefferson, NY 11777

Entity's or Person's Phone: (631) 473-1320, x4259

Dates and Amounts of Contributions from Entity or Person:

Date Contribution Received: 07 / 24 / 2012 Amount of Contribution: \$3942 .00

Date Contribution Received: 10 / 12 / 2012 Amount of Contribution: \$3942 .00

Date Contribution Received: / / Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Related or Affiliated Entity or Person:

Entity's or Person's Full Name:

Entity's or Person's Address:

Entity's or Person's Phone:

Dates and Amounts of Contributions from Entity or Person:

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Check here if using section V(B) of the Addendum for additional Related, or Affiliated Entities or Persons: ☐

Contributions from Single Source #2

Related or Affiliated Entity or Person: Brookhaven Memorial Hospital Ctr

Entity's or Person's Full Name:

Entity's or Person's Address: 101 Hospital Rd, Patchogue, NY 11772

Entity's or Person's Phone: (631) 654-7100

Dates and Amounts of Contributions from Entity or Person:

Date Contribution Received: 07 / 30 / 2012 Amount of Contribution: \$2125 .00

Date Contribution Received: 11 / 14 / 2012 Amount of Contribution: \$2125 .00

Date Contribution Received: / / Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Related or Affiliated Entity or Person:

Entity's or Person's Full Name:

Entity's or Person's Address:

Entity's or Person's Phone:

Dates and Amounts of Contributions from Entity or Person:

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Check here if using section V(B) of the Addendum for additional Related, or Affiliated Entities or Persons: ☐

Check here if there are Contribution(s) from Single Source(s) other than those listed above. Use Section V(B) of the Addendum to list all such Contributions: ☒

Designated Addendum sheet for section V(B)

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

Source of Funding Disclosure**B Single Source information for a Contribution(s) from multiple, Related, or Affiliated Entities.****Single Source #3**

Related or Affiliated Entity or Person: New York Hosp Med Ctr Qns

Entity's or Person's Full Name:

Entity's or Person's Address: 56-45 Main St, Dept Anesthesia, Flushing, NY 11355

Entity's or Person's Phone: (718) 670-1380

Dates and Amounts of Contributions from Entity or Person:

Date Contribution Received: 11 /30 /2012 Amount of Contribution: \$ 2134 .00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Related or Affiliated Entity or Person:

Entity's or Person's Full Name:

Entity's or Person's Address:

Entity's or Person's Phone:

Dates and Amounts of Contributions from Entity or Person :

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Single Source #

Related or Affiliated Entity or Person:

Entity's or Person's Full Name:

Entity's or Person's Address:

Entity's or Person's Phone:

Dates and Amounts of Contributions from Entity or Person:

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Related or Affiliated Entity or Person:

Entity's or Person's Full Name:

Entity's or Person's Address:

Entity's or Person's Phone:

Dates and Amounts of Contributions from Entity or Person:

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Date Contribution Received: / / Amount of Contribution: \$.00

Subjects lobbied:

☐ Continued on attached pages

Person, State Agency, Municipality or Legislative Body lobbied:

☐ Continued on attached pages

Bill, Rule, Regulation, Rate Number or brief description relative to the introduction or intended introduction of legislation or a resolution on which you lobbied:

☐ Continued on attached pages

Title and Identifying Numbers of procurement contracts/documents lobbied:

☐ Continued on attached pages

Number or Subject Matter of Executive Order of Governor/Municipality lobbied:

☐ Continued on attached pages


Subject Matter of and Tribes involved in tribal-state compacts, etc lobbied:

☐ Continued on attached pages

Declaration

This Declaration must be signed by the Chief Administrative Officer. (If the Chief Administrative Officer, for any reason, does not sign, he/she must duly designate another person to sign this Declaration.) **(See instructions.)**

I declare under penalty of perjury that the information contained in this report is true, correct, and complete to the best of my knowledge and belief.

X SIGNATURE:  **DATE:** January 15, 2013

PRINT NAME: LAST DEARS **FIRST ELIZABETH**

TITLE: Senior Vice President/Chief Legislative Counsel

Mark One: ☐ Chief Administrative Officer ☐ Designee(Attach Letter)

The following MUST be attached to this report at the time of submission:

- You must attach a **\$50 dollar filing fee** to each semi-annual report. (No fee is required for amendments to the original)
- If applicable, a designation letter if you have marked designee in section XI.
- If applicable, continuation sheets for sections III, IV, V, VI, VII, VIII, IX and X.

PLEASE NOTE You may be assessed up to \$25 for each day this report is late.